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Deprivation is a relative concept? Absolutely!

Wilkinson and Pickett's (WP) theory has relative deprivation as a core mechanism for why income inequality impacts health in societies [1]. A number of recent studies, including in JECH, have thus contrasted the health impact of relative to absolute deprivation [2,3]. However it is a false contrast I argue. This is because supposed absolute deprivation has its roots in a theory of relative deprivation [4, 5]. Further it is not only WP's theory that has relative deprivation as its core mechanism. Materialist / structural theory, as outlined in the very well-known Black report on health inequalities, does as well [6]. Absolute deprivation is often defined as one's material standard of living up to some set level, for example a subsistence level, and as one's material standard of living independent of that of others [3]. However, the Black report discusses in detail why materialist / structural theory sees the unequal access due to social class of economic and other resources as the key driver of health inequalities because it deprives people of contemporary standards of living [6]. So there is a clear endorsement of deprivation as relative and a move away from notions of absolute deprivation and health in the report.

"There is nothing fixed about levels of physical well-being. They have improved in the past and there is every likelihood that they will improve in the future. But class inequalities persist in the distribution of health as in the distribution of income or wealth, and they persist as a form of relative deprivation." [6](p109)

This emphasis on relative deprivation is not surprising as Peter Townsend was one of the Black report's authors. He was a key theorist for why deprivation is relative not absolute, and the originator of an influential relative deprivation scale that has inspired many other relative deprivation scales [4, 5, 7]. Yet these deprivation scales, or their proxies, are continually treated as absolute deprivation in health inequalities studies that aim to contrast relative and absolute deprivation in order to test WP's theory [2, 3]. WP themselves have argued that within country deprivation income scales in rich countries are relative rather than absolute [1].

While researchers exploring WP's income inequality theory have recognised Townsend's relative deprivation theory they are most influenced by Runciman's much cited study which focused on people's perceptions or feelings of deprivation relative to others [8]. Often researchers study the health impact of relative deprivation by transforming their deprivation measure using a formula derived from Runciman's work [3]. They then compare its health effect to that of absolute deprivation. But as discussed, these deprivation measures are relative in the first place rather than absolute measures. So researchers are effectively transforming a relative deprivation measure into another relative deprivation measure and then contrasting one relative deprivation measure to another. Furthermore, Runciman also rejected the idea that relative deprivation implied an absolute opposite.

"...the notion of relativity implied by 'relative deprivation' has led some writers to feel that there must be some wants or needs which could be termed 'absolute' deprivation – wants, that is, which are independent of the situation of any other person or group, and which can be assessed by appeal to some ideal yardstick such as 'minimum need' or 'subsistence level'. But this idea breaks down

under close scrutiny.... The level of so-called absolute need can be just as well fixed at one level as another.” [8] (p 295)

So both materialist and WP's income inequality theory have relative deprivation theories at their core and both these relative deprivation theories reject the idea of absolute deprivation. This suggests that there is a need to reflect on what the actual contrast is and what researchers are aiming to study when claiming to contrast absolute to relative deprivation. Often the reference level or group of the two deprivation measures may be different, one (usually the untransformed “absolute” deprivation) may be at the national level while the other may be sub-national whether this be a geographical level or a group [3], so the contrast may be between the importance of deprivation with different reference levels rather than between absolute and relative. Indeed WP argue that relative deprivation at the national level rather than a sub national level is more important given a stronger relationship between income inequality and health at the national rather than local level [1]. Of course WP's theory uses absolute to describe international comparisons of income and health however relative deprivation theory extends to international comparisons as well [4, 5].

There are those who wish to retain absolute concepts of deprivation, most famously Amartya Sen in his work on capabilities. However this is a more complex use of absolute than the simple definition of absolute used in studies comparing relative to absolute deprivation. Sen argued that “Especially against the simplistic absolute conceptualisation of poverty, the relative view has represented an entirely welcome change” with his view being “that absolute deprivation in terms of a person's capabilities relates to relative deprivation in terms of commodities, incomes and resources.” [9], p153

Obviously WP's income inequality theory emphasises relative deprivation as being psychosocial deprivation leading to stress and poor health behaviours and thus poor health, rather than the direct effects of deprivation of physical living conditions [1]. However, materialist theory and Townsend's relative deprivation theory have always incorporated physical, social and status deprivation [4,5, 6], as has long been recognised [10]. For Townsend, the contrast between his definition of relative deprivation and Runciman's was the emphasis given to objective conditions of living compared to subjective perceptions of deprivation [4, 11]. This contrast between feelings and conditions has featured in the health inequalities literature as well when highlighting the difference between WP's income inequality theory and materialist theory [12]. While Runciman's study focussed on subjective feelings of deprivation, Townsend's work emphasised the actual conditions of deprivation.

“Subjective (or collective sentiment about) deprivation is a valuable analytical or explanatory variable. However, it cannot be fully assessed independently of actual deprivation, and the latter could be argued to be primary in understanding a whole range of social and psychological phenomena .” [11] (p35)

Runciman's book was a study of the degree of (mis) match between actual conditions of deprivation and people's perception of their deprivation [8] and health inequalities studies have compared the relative health impact of subjective versus objective socio-economic circumstances [3]. However because income inequality implies real differences in income and living conditions WP's theory does not seem to imply that these feelings of deprivation arise without there being actual differences in economic resources or living conditions. Just that these differences in living conditions mostly have a psychosocial meaning and impact rather than a “direct” effect on health in rich societies. Thus the

defining difference between WP's theory and materialist theory may not be subjective versus objective either.

There are other differences between materialist and WP's theory that could be discussed but space is limited. Also I have only very briefly touched on Townsend and Runciman's relative deprivation theories and their full appreciation is beyond the scope of this editorial. However, the important point is that materialist and WP's theory both have relative deprivation at their core. This challenges us to move beyond theoretically unsupported notions of "absolute" deprivation when considering the effect of the complex interplay of economic growth and (re)distribution [11] on health.

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